



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Doctors Hospital at Renaissance

Respondent Name

International Paper Co

MFDR Tracking Number

M4-17-3220-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

July 03, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be applying the Medicare facility specific amount.

After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 15240, allowed amount of \$1,258.66 multiplied at 200% and CPT Code 96374, allowed amount of \$158.48, multiplied at 200 reimbursements should be \$3,233.72. Payment received was only \$2,916.75, thus, according to these calculations: there is a pending payment in the amount of \$316.97."

Amount in Dispute: \$316.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent stands by the original payment for the service in dispute. Requestor was reimbursed pursuant to the Medicare fee guidelines for the total outpatient procedure. Some billed services are not paid separately. Therefore, no additional monies are owed for the date of service 4/13/17."

Response Submitted by: Downs Standord PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2017	Code 96374	\$316.96	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON RE VIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
 - 906 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING INITIATIVE/OUTPATIENT CODE EDITOR), COMPONENT CODE OF COMPREHENSIVE MEDICINE, EVALUATION AND MANAGEMENT SERVICES PROCEDURE
 - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute regards outpatient hospital services with reimbursement subject to the division's *Hospital Facility Fee Guideline—Outpatient*, at 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) be calculated using the Medicare facility specific amount (including outlier payments) as determined by the applicable Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors, published annually in the Federal Register, with modifications as set forth in the rules.

Rule §134.403(f)(1) requires that the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables.

3. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

Reimbursement for the disputed services is calculated as follows:

- Per Medicare policy, procedure code 96374 may not be reported with code 15004 and 15240 billed on the same claim. Reimbursement for this service is included with payment for the primary procedure. Separate payment is not recommended.
4. The total recommended reimbursement for the disputed services is \$2,916.78. The insurance carrier has paid \$2,916.75. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

9/29/2017
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.